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ABSTRACT

This manual of resources for alcohol and other drug abuse education in medical schools and residency programs establishes basic learning goals, and objectives for teaching drug abuse units that reflect the philosophy of family medicine. The manual was developed using data and curriculum material collected through a detailed curriculum survey of the members of the Society of Teachers of Family Medicine. After a first chapter outlining the minimum knowledge and skill goals for all practicing physicians, a second chapter delineates knowledge and skill objectives for alcohol and other drug abuse teaching particular to family medicine. The third chapter suggests a model for integrating the objectives of knowledge, skill and attitude into an over all curriculum. Chapter 4, Learning Experiences and Strategies, includes an analysis of the data gathered by the curriculum survey. A fifth chapter on evaluation principles and methods includes an example of an evaluation assessment tool. The last chapter, Curriculum Examples, describes a few actual programs in depth and includes a contact person, telephone number and address for each. An extensive final section, titled Learning Materials, contains a bibliography of approximately 125 items, a list of 32 audiovisual materials, and a list of 10 resource institutions providing educational materials. (JB)

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Resource Manual for Alcohol and Other Drug Abuse Education in Family Medicine Medical School and Residency Programs

Society of Teachers of Family Medicine

IE 024 447

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Public Health Service
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Society of Teachers of Family Medicine

Final Report
Prepared under contract no. ADM 281-85-0012

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
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PREFACE

In 1985, the Society of Teachers of Family Medicine, in common with sister organizations representing primary care internal medicine, pediatrics, and psychiatry, was awarded a contract to determine the extent and quality of teaching in alcohol and other drug abuse within the specialty. Consensus statements on educational goals reached at interdisciplinary meetings were refined and modified as the project progressed.

This manual begins with a list of broad goals, endorsed by the four specialties contributing to this project, that summarizes the minimum knowledge and skills desirable for practicing primary care physicians. A list of educational objectives follows that was developed by the Society of Teachers of Family Medicine Advisory Committee and is recommended as a curriculum planning tool for departments of family medicine.

Through a detailed survey of its membership, a substantial set of data and curriculum materials were collected. This manual includes recommended learning experiences and strategies, strategies for evaluation, examples of curricula, and a discussion of common difficulties, problems, and weaknesses with some recommendations from the Society of Teachers of Family Medicine Advisory Committee. The appendices contain information on educational material resources and bibliographies on educational strategies for alcohol and other drug abuse teaching for medical education.

Any manual of this nature has its limitations. Medical schools and residency programs differ greatly in their structure, philosophy, and the ease with which new curriculum units can be introduced or existing units redesigned. Faculty and student attitudes toward the subject of alcohol and other drug abuse, resistance to multidisciplinary teaching, lack of curriculum time, or simply a lack of faculty expertise may appear to block curriculum development in this area. The effort required to introduce this new material will be considerable, but we hope that family medicine faculty will rise to the challenge and will find this document helpful in integrating this topic into their existing teaching and in working with colleagues in other clinical departments to improve the medical school curriculum.

INTRODUCTION

The Society of Teachers of Family Medicine (STFM) Advisory Committee considered numerous educational objectives in the final selection of appropriate educational goals and objectives in alcohol and other drug abuse for family medicine. This serves as the foundation on which other sections of this manual are built.

The task of establishing these learning goals and objectives required our committee to examine some overall, generic issues, which serve as the premises for our rationale. We would like to begin this document with a statement of some of these premises.

Family Medicine Emphasis

An adequate understanding of alcohol and other drug abuse necessitates input from virtually all specialties of medicine in addition to nonmedical specialties. Therefore, it is incumbent upon each specialty to delineate the unique scope of its own curriculum in alcohol and other drug abuse, which should offer a specialty-specific perspective while at the same time augmenting the total medical school curriculum. The common ground should be taught in a complementary, reinforcing fashion through a collaborative interspecialty effort.

To complement and augment the work of other specialties, this report focuses on learning goals and objectives that reflect the philosophy of family medicine. The emphasis is on issues related to the family impact of alcohol and other drug abuse as well as the continuum of care extending beyond the physician's office. Because our focus is on that portion of an alcohol and other drug abuse curriculum that fits best within family medicine's overall contribution to medical education, we expect that any gaps in the curriculum, for example, in the basic sciences, would be filled by other medical specialties or nonmedical disciplines. Therefore, we see the learning goals and objectives for family medicine as integrated into a total curriculum for medical education.

It is important to point out, however, that it is family medicine's overall goal to ensure that all practicing family physicians have at their disposal a cadre of skills providing them with the ability to diagnose alcohol and other drug abusing patients in their practices and to manage those patients as they would anyone else, i.e., treat them in a professional manner to the best of their ability.

Attitudes

One of the most potent blocks to the introduction of alcohol and other drug abuse curriculum is the attitude of faculty, students, and residents, whether born of anxiety from lack of knowledge or a moralistic or legalistic view. We feel that certain attitudes are fundamental to successful teaching in alcohol and other drug abuse and should be integrated throughhout every phase of a curriculum, including faculty development.

It is the opinion of the STFM Advisory Committee, strongly supported by the literature, that successful training in alcohol and other drug abuse must be built on a positive attitude toward the treatment of patients with this group of illnesses. Therefore, as a prerequisite to curriculum planning and development, the issue of attitudes must be addressed and should be included in teaching at all phases, especially early on. The attitudes necessary for clinical effectiveness in the recognition and treatment of alcohol and other drug abuse imply the acceptance of certain professional obligations:

- to become informed about the illness and

recognize its effect on the individual, family, and community;

- to recognize the illness; and
- to manage the illness or refer appropriately.

In addition, family physicians must have an attitude of willingness to recognize their own strengths and limitations in managing the illness. Adoption of this attitude presupposes recognition of the following professional obligations:

- to be informed about other professional and lay resources available to manage the illness; and
- to cooperate with other professional and lay resources for management of the illness.

Lastly, the family physician must have an attitude of awareness of the medical profession as a group at risk for alcohol and other drug abuse. Adoption of this attitude implies recognition of the following professional obligations:

- to participate willfully in personal risk assessment for potential alcohol or drug abuse problem;
- to recognize alcohol or other drug abuse in a colleague; and
- to take appropriate action when alcohol or other drug abuse is recognized in a colleague.

MINIMUM KNOWLEDGE AND SKILL GOALS FOR PRACTICING PHYSICIANS

The purpose of this statement is to broadly describe the minimum knowledge and skills in alcohol and other drug abuse for practicing physicians including general internists, psychiatrists, family physicians, and pediatricians. This body of knowledge is being presented because the practicing physician is at the forefront of prevention and management of this important problem.

Physicians should accept alcohol and other drug abuse as medical disorders. They should be informed about alcohol and other drug abuse disorders; recognize the effects on the patient, the family, and the community; and be able to diagnose and treat these disorders. Physicians should recognize their personal strengths and limitations in managing patients with alcohol and other drug abuse.

General Concepts

The practicing physician should understand the following general concepts of alcohol and other drug abuse:

- Common definitions
- Diagnostic criteria
- Epidemiology and natural history
- Risk factors, including familial and social cultural factors as well as current genetic and biologic theories
- The relationship of this group of disorders to the functioning of the family

Prevention

Practicing physicians should understand their role in the prevention of alcohol and other drug abuse problems through:

- Patient education
- Risk identification
- Prescribing practices

Pathophysiology

The practicing physician should understand the following:

- The pharmacology and behavioral effects of commonly abused substances
- The physiology of intoxication, dependence, tolerance, and withdrawal
- Pathological effects of acute and chronic drug and alcohol abuse on organ systems

Evaluation of the Patient

The practicing physician should be aware of specific presenting complaints suggestive of alcohol and other drug abuse. In addition, physicians should be able to screen effectively for the early and late manifestations of alcohol and other drug abuse including behavioral manifestations. Once abuse is suspected in an individual patient, physicians should be able to confirm the diagnosis by obtaining a detailed alcohol and drug use history, identifying physical findings suggestive of substance abuse, and interpreting the results of selected laboratory tests.

The practicing physician should be aware that alcohol and other drug abuse disorders may present as other medical or psychiatric disorders or may be complicated by the presence of psychiatric or medical comorbidity.

The practicing physician should be aware that denial in the patient, family, and physician delays recognition and treatment.

Management

Practicing physicians should be able to directly manage or refer patients for treatment of acute intoxication, overdose, and withdrawal. They should be able to motivate the patient for further treatment and select an appropriate management plan from available treatment options, bearing in mind the patient's needs and community resources. They should be knowledgeable of the various treatment alternatives and the expected outcomes of treatment.

Physicians should recognize their own responsibility in the long-term management and followup of patients with alcohol and other drug abuse.

The practicing physician should be familiar with the philosophy and availability of self-help groups for the patient and family, such as Alcoholics Anonymous and Al-Anon.

Legal Aspects

The practicing physician should know the legal aspects of informed consent, release of information, and obtaining blood, urine, and breath tests in screening for alcohol and other drug use.

Health Professional Impairment

The practicing physician should be aware of health professionals as a group at risk for alcohol and drug problems and be aware of the resources available for impaired colleagues.

Medical Students

Medical students should be aware of the prevalence of patients with alcohol and other drug abuse in all medical settings. Students should have the same fund of knowledge in this area as practicing physicians. Students should also be capable of screening for alcohol and other drug abuse in the course of performing a history and physical examination and should be able to take a detailed alcohol or drug use history when appropriate. Students should be aware of different treatment modalities and expected outcomes, but are not expected to have the skills necessary to treat patients for their primary problems.

FAMILY MEDICINE KNOWLEDGE AND SKILL OBJECTIVES FOR ALCOHOL AND OTHER DRUG ABUSE TEACHING

Family medicine has a unique strategic advantage in detection and management of the alcohol or other drug abusing patient. If alert and knowledgeable, family physicians understand the newer genetic data about alcoholics and can use family-centered techniques such as genograms to further assess an at-risk population. In following children, they can use early-intervention strategies and patient education with a population where prevention is of utmost importance. Additionally, although abusing patients may be able to avoid visiting the family physician, the members of their families are likely to present with a myriad of complaints and signs of dysfunction. This allows the family physician to intervene whether or not the index patient is helped.

Adequate preparation for the practice of the specialty of family medicine requires that the following objectives be met. All of them can be prefaced with the clause: "The resident family physician, by completion of training, will know/be able to ___." Where possible, they have been worded in such a manner as to lend themselves to testing.

General Knowledge

Knowledge Objectives

1. General statistics related to alcohol and other drug abuse in American society, i.e., overall cost in dollars, human lives, family violence, physical and mental abuse, child abuse, and prevalence of substance intake (by major types) in the general population
2. Natural history of alcoholism and other drug abuse, which can be conceptualized as a paradigm of a chronic, progressive, relapsing family illness
3. At least three common definitions and criteria and three myths of alcoholism and other drug abuse and one definition appropriate for family medicine
4. Differences in alcohol content, labeling, advertising, and marketing for a minimum of three types of beverages
5. General facts about the history of alcohol use and abuse and other drug use and abuse in a social context

Family Illness/Systems Issues

Knowledge Objectives

1. Family transmission patterns through generations
2. Basic premises of family systems theory
3. Differences between family dynamics in healthy families and those with an alcohol or other drug abusing member
4. Red flags for raising index of suspicion within a family
5. Progression and stages of family alcohol and other drug abuse and dependence
6. Observable and documentable family-enabling types of behaviors
7. Treatment resources available for family members with and apart from the substance-abusing patient
8. Available resources in the community specializing in family support (e.g., Al-Anon) and resources available to make initial contacts

9. Frequency of increased occurrence in other members of a family with one alcohol or other drug-abusing member

10. At least two techniques for communicating with children

11. The power of family and social pressures to drink and the critical role of the family in relapse prevention

12. General family counseling principles relative to alcohol and other drug abuse and family therapy options

13. Characteristics of adult children of alcoholics and the prevalence of related problems

Skill Objectives

Motivate families for treatment and recovery and initiate family counseling/therapy or referral for such families in at least one situation even if the patient refuses treatment.

Epidemiology

Knowledge Objectives

1. Risk factors for alcohol and other drug abuse with specific attention to subpopulations

2. Major genetic theories and evidence in relation to alcoholism

Skill Objectives

Detect a minimum of 10 at-risk patients by virtue of their sociocultural background information and implement a method for continued, periodic review of those patients' patterns of alcohol and/or other drug use. (This can then be documented as part of recertification.)

Prevention

Knowledge Objectives

1. Understanding the family physician's unique advantage in prevention and detection

2. At least two available patient education techniques

3. Two kinds of community public relations preventive strategies

4. Fetal Alcohol Syndrome criteria, statistics, detection methods, resources available, and implications for unborn and newborn children and mothers

5. Understanding how advertising encourages increased consumption and use by adolescents

Skill Objectives

1. Initiate a risk-reduction intervention (e.g., behavior modification, educational interventions) with at least five patients in the family practice setting

2. Initiate counter-advertising strategies within the family practice office

Pathophysiology

Knowledge Objectives

1. The meanings of intoxication, tolerance, and dependence as they apply to alcohol and other drug abuse

2. Absorption, metabolism, and distribution of alcohol and other major drugs of abuse

3. Major complications categorized by body systems

4. Alcohol or other drug abuse masquerading as other medical symptoms

5. Complications borne out through unexpected data sources (e.g., radiology data, emergency room data)

6. Recent biomedical developments in addiction

Differential Diagnosis and Diagnosis

Knowledge Objectives

1. How to use and interpret the Michigan Alcoholism Screening Test (MAST), Short Michigan Alcoholism Screening Test (SMAST), and Cutting Down Annoyance From Criticism Guilty Feelings Eye-openers (CAGE) screening instruments
2. At least two alcohol detection and drug monitoring techniques available in the office setting
3. Indicators of dual diagnosis (psychiatric and alcohol or other drug abuse problem)
4. Cross-addiction potential: concomitant use of drugs masking or altering signs of abuse in a patient

Skill Objectives

Interpret CAGE and MAST data in relation to other diagnostic factors from the history, physical exam, and laboratory investigations in a minimum of two patients who have aroused physician's suspicions. Document in patient record.

History Taking

Knowledge Objectives

1. What questions to ask in a routine examination
2. What questions to ask if suspicion is aroused
3. Areas of a history likely to be high-yield in terms of identifying an alcohol or other drug abuse problem
4. Clues to a problem found in the style of a patient's or family member's response to questioning

Skill Objectives

Follow up on all suspicions aroused in a routine alcohol and other drug history with thorough and directed line of questioning.

Physical Examination

Knowledge Objectives

1. Common early, middle, and late manifestations
2. The common lack of signs in the early stages
3. Physical signs associated with abuse of one drug masking abuse of another

Skill Objectives

Interpret physical exam findings in relation to alcohol and other drug use and abuse in at least five patients who have aroused the physician's suspicions. Document relevant conclusions in patient record.

Laboratory Investigations

Knowledge Objectives

1. What supporting tests are available
2. Common early, middle, and late manifestations
3. The common lack of physical signs in early stages
4. Cross-addiction potential: concomitant use of drugs masking or altering signs of alcohol or other drug abuse

Skill Objectives

Interpret laboratory test findings in relation to alcohol and/or other drug abuse in a minimum of two patients who have aroused the physician's suspicions and document in the patient record.

Intervention

Knowledge Objectives

1. An actual "diagnosis" written in the

chart need not be made to warrant an intervention

2. Intervention is always important

3. At least two methods to attack the denial and the different manifestations of denial

4. Ingredients of confrontation

5. Common reactions to confrontation

6. Intervention techniques available in the community and office

7. At least two motivating and counseling techniques

8. Awareness of "failure" versus "success" in the context of confronting an alcohol or other drug abuser or family member

9. The continuum of confrontation involves a longitudinal process using various strategies and opportunities

Skill Objectives

1. Participate in a minimum of one conference to motivate a patient for treatment and recovery

2. Participate in a negotiation session with a patient and family for treatment with attention to the "critical moment" of timing in initiating this negotiation process

3. Initiate arrangements for or assist in conducting an intervention to directly confront the denying patient; document in patient record

Acute Management

Knowledge Objectives

1. Indications for outpatient and inpatient detoxification

2. Complications of detoxification: essential elements and pitfalls

3. Natural course of withdrawal and stages

4. Differences in withdrawal pattern seen in different drugs, e.g., sedative hypnotics, stimulants, alcohol

5. Sedative substitution in withdrawal and other techniques of withdrawal

6. Indications and techniques for nonmedical detoxification

7. Resources available in the community for detoxification

8. Essential elements of making a contract with a patient

9. Characteristics of patient motivation as they impinge on success of detoxification

10. Incidental withdrawal signs and management strategies

11. Monitoring and following detoxification progress

Skill Objectives

1. Determine which patients to detoxify in a group of five alcohol-abusing patients

2. Determine where to detoxify those patients

3. Conduct detoxification of at least one patient using a non-drug regimen and one patient with a drug regimen, with full patient record documentation

4. Anticipate complications of detoxification and refer patient if necessary

5. Make appropriate arrangements (refer or followup) after detoxification for a minimum of two patients and document

Referral

Knowledge Objectives

1. Indications of when to refer and to

whom to refer

2. Steps necessary to follow up on a patient entering a formal treatment program

3. Physician's responsibilities and level of involvement in different types of treatment programs

4. What other specialties can offer in terms of referral, e.g., family therapist, nephrologist, gastroenterologist, alcohol/drug abuse counselor

5. Major patient selection characteristics by programs

6. Program characteristics for patient selection

7. Financial requirements of patients for treatment and common financial plans available

Skill Objectives

1. Evaluate at minimum two patients for a program/resource and the programs/resources for those patients

2. Participate in an aftercare planning conference with at least two patients and their families; document in patient record

Self-Help Groups

Knowledge Objectives

1. Principles and roles of AA, Al-Anon, Narcotics Anonymous (NA), and other self-help groups in intervention and recovery

2. General principles of AA

3. General progression of steps of AA and Al-Anon

4. Requirements for membership in AA and Al-Anon

5. General philosophy of AA, Al-Anon, NA, etc.

6. Availability of NA and other self-help groups in the community

7. Availability of resources (e.g., AA members) in the community to assist patients in making initial contact with self-help group

8. What educational and self-instructional materials are available or how to access that information

Skill Objectives

1. Assist two patients in making initial contact with AA or other self-help group and document with attendance slips

2. Attend at least three AA meetings and two Al-Anon meetings

Long-Term Management

Knowledge Objectives

1. At least three different treatment philosophies

2. Outpatient versus inpatient treatment indications and differences between the two kinds of treatment

3. Outcome data or results of at least three modalities with an assessment of that information for use in recommending programs

4. Managing relapse

5. Attention to prescription and over-the-counter drug use

6. Monitoring family adjustment and coping

7. Encouraging continued involvement in AA and Al-Anon for family

8. Indications and contraindications for use of disulfiram

9. Health modification techniques

10. Smoking cessation and implications of other addictive behaviors

11. Chronic pain management and iatrogenic and nonsanctioned drug use

12. Ways Employee Assistance Programs can be useful resources in long-term management

Skill Objectives

1. Identify an alcohol abuser in the family practice setting and, after assessing the situation, develop and carry out a management plan with that person and the family, with full documentation in the patient record

2. Prevent, where possible, and manage relapse

3. Conduct perioperative management with one patient

4. Treat intercurrent psychiatric and medical illnesses or behavioral problems within the context of alcoholism or other drug abuse history in one longitudinal patient, with full patient record documentation

5. Prescribe and follow up the use of disulfiram in management

Use of Psychotropic Medications

Knowledge Objectives

1. Prevalence of hazardous drugs and drugs/medicines containing alcohol

2. Indicators for when to use psychotropic medications in management

3. Contraindications for use of psychotropic medications in management

4. Addiction potential for patients being managed for pain, anxiety, insomnia, and depression

Skill Objectives

1. Determine at least five situations where pharmacologic intervention may be inappropriate for treatment of intoxication or withdrawal

2. Prescribe all medications with full knowledge of consequences for recovering alcoholics or other drug abusing patient.

Therapeutic Relationship

Knowledge Objectives

1. One's own personal and professional limitations in managing alcohol or other drug abuse

2. Alcohol and other drug abuse comprise a very common illness presenting in family practice

3. The role alcohol and other drugs play in one's own life and in the lives of families in society in general

4. Characteristics of a physician's role in the long-term management of alcohol and other drug abuse

Skill Objectives

1. Participate in a planning meeting with other health care professionals regarding long-term goals for at least one patient

2. Evaluate appropriate physician role in the long-term management of at least one patient and implement plans based on that evaluation.

Legal Aspects

Knowledge Objectives

1. Legal issues involved in drug screening

2. Legal implications of a diagnosis in a patient's record and confidentiality laws regarding alcohol and drug use and abuse

3. Use of prescriptions

Health Professional Impairment

Knowledge Objectives

1. Demographics of alcohol and drug abuse in physicians and other health professional groups
2. High-risk specialties
3. Signs and symptoms to alert attention to self or colleague
4. Special features of physician alcohol and other drug abuse versus other professional groups
5. Contributory factors to physician alcohol and other drug abuse
6. Outcome study results
7. Characteristics of resources available within institution or community
8. State's Impaired Physician programs
9. Aid to Impaired Medical Students (AIMS) programs
10. Self-help groups for physicians with alcohol and drug problems, e.g., International Doctors in AA

Skill Objectives

1. Initiate an appropriate intervention step if an alcohol or other drug abuse problem manifests in self or a colleague
2. Freely discuss drug and alcohol use and personal risk with colleagues

LEARNING OBJECTIVES BY EDUCATIONAL LEVEL

Model for Curriculum Integration

A model for integration of topics and knowledge, skill, and attitude objectives into an overall curriculum in family medicine across levels of education is shown in figure 1. The three dimensions can be seen as representing the following concepts:

Horizontal: Comprehensiveness of the curriculum in terms of the number of topics introduced at each of the four educational levels. Of particular note here is the pyramid structure, adding topics with each level.

Vertical (across all four boxes): The continuum of the curriculum over time or over the four levels of education.

Depth: 1. The comprehensiveness (or depth) of skill objectives. The differences in depth across levels reflects the differences in emphasis on skill development by level in the curriculum. Note the relatively big jump in skill development between medical school and residency and between CME and fellowship levels.

2. Attitudes. Attitudes as an integral part of all curricula at all levels.

Topics

Twenty topics are listed below in order of the priority for family medicine curriculum assigned them by the committee.

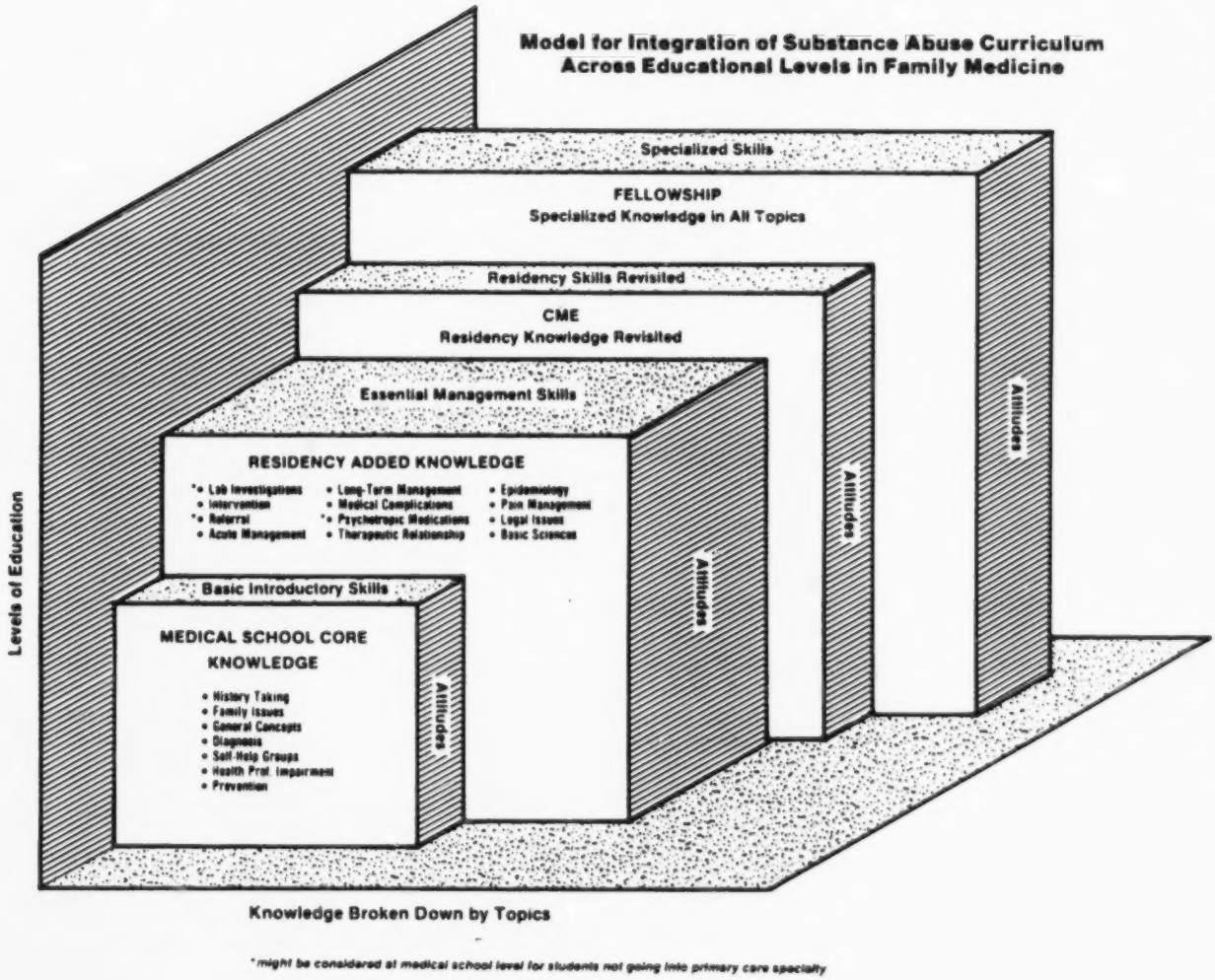
History Taking
Family Illness/Systems Issues
General Concepts
Differential Diagnosis and Diagnosis
Self-Help Groups (e.g., AA)
Physician Impairment
Prevention
Acute Management
Long-Term Management
Physical Examination
Intervention
Referral
Therapeutic Relationship
Epidemiology
Medical Complications
Laboratory Investigations
Psychotropic Medications
Basic Sciences
Legal Issues
Chronic Pain Management

Learning objectives over time reflect a "building block" structure, with all topics included before the CME level as indicated in the model. In general, as one might expect, clinical emphasis and level of sophistication increase over time.

It should be stressed that, although the topics are given in order, the consensus of the committee is that all of these topics are important for a comprehensive curriculum in family medicine. The ordering assists in ascertaining which we consider to be core topics and, thus, important for early inclusion in the overall curriculum (i.e., medical student level).

Attitudes

Teaching directed at attitudes must be an integral part of any curriculum addressing alcohol and other drug abuse in family medicine. The strong consensus of the committee is that attitude objectives must be included and integrated throughout all teaching. A curriculum ***at all levels*** should strive to achieve one overall set of attitudes. Thus, attitude objectives are visually depicted as a depth dimension across all levels.



*might be considered at medical school level for students not going into primary care specialty

Knowledge

Basically, one body of knowledge is necessary to adequately diagnose and manage alcohol and other drug abuse in family medicine, but it cannot all be taught at any one level. Therefore, for each level of education (undergraduate, residency, CME/subspecialty, fellowship), the suggested body of knowledge is broken down by topic and ultimately builds on itself. The model might be represented by a pyramid-shaped comprehensive knowledge base with increasing scope over the course of medical education. This kind of framework implies that a learner at one level must have acquired the body of knowledge of the previous level in order to progress through the curriculum. Also inherent in this approach is the notion that the performance of one skill (psychomotor task) at a particular level requires varying bits of knowledge from several topics that are covered in the curriculum at that level, or that were acquired at an earlier level.

Skills

Skills increase over time in a manner consistent with the abilities at each educational level. Our basic structure assumes that a resident will have acquired the core knowledge of a graduating medical student by the time of the first year of residency (or the first year of the residency curriculum would ensure that all residents reach this goal). This structure, however, does not imply that medical education can adequately address all the essential skills for all of the topics addressed in the 4-year medical school curriculum. Core topics need to be "revisited" in a more sophisticated fashion at residency/CME levels.

Skills for the adequate preparation for the resident family physician (resident and/or CME level) are specified under the seven general goal headings. Less sophisticated skills for medical school education are not included in that discussion.

Next, we demonstrate how skills for core topics (i.e., medical school topics) might be taught to accommodate that level of education.

Undergraduate Level Skills in Core Topics

By graduation, every medical student should be able to perform the following tasks. They are worded so as to be measurable in behavioral terms.

Prevention

Give five family practice patients an overview on alcohol and other drug use/abuse in our society.

Assess these same five patients' risk for becoming an alcohol or other drug abuser.

History Taking

Take an alcohol and other drug history from every patient as part of initial workup.

Differential Diagnosis and Diagnosis

Administer the CAGE and MAST to one classmate and have it administered to self by classmate.

Use and explain the CAGE and MAST results to a minimum of two patients seen in the family practice setting.

Physical Examination

Conduct a routine physical exam on five patients in the family practice office with attention to physical signs (or the absence thereof) that could suggest an alcohol or other drug abuse problem.

Self-Help Groups (AA and Others)

Evaluate AA as a resource by attending at least one open meeting.

Review available patient education materials put out by self-help groups in the community.

Family Illness/Systems Issues

Interview at least two family members with attention to possible alcohol and/or other drug abuse situations through family and social red flag data.

Health Professional Impairment

Recognize self and peers as belonging to

a profession at risk for alcohol and other drug abuse through discussion with class-mates of family's and self's pattern of alcohol and other drug use.

LEARNING EXPERIENCES AND STRATEGIES

Teaching Strategies

The curriculum survey conducted by STFM gathered information on teaching strategies used in family medicine alcohol and other drug abuse teaching units. The survey looked at classroom teaching strategies, opportunities for individual learning, and clinical experiences at both residency and medical school levels. With the exception of research, which was given a very low priority at both educational levels, most teaching involves a variety of techniques, both didactic and experiential. The lecture still predominates as the most common teaching strategy. Clinical experiences tend to be emphasized more frequently in residency teaching, whereas students are exposed to more reading and films. The breakdown is shown in table 1.

Respondents to the survey were also asked to indicate who in their program was responsible for teaching the alcohol and other drug abuse units. In only 41 percent of the units was a family physician teaching the material at all, and in 15 percent the only teacher was a family physician. Many other teachers were used, predominantly behavioral scientists and alcohol and other drug abuse counselors.

Many respondents to the curriculum survey indicated plans to expand or refine current curriculum in alcohol and other drug abuse. Particular concerns appeared to be a desire to improve community-based clinical experiences and to improve the relevance of teaching to clinical practice.

Recommendations of the Committee

Desirable strategies to consider in the development or expansion of a family medicine alcohol and other drug abuse curriculum include:

- Involvement of community treatment staff in curriculum planning

Involving community treatment staff in curriculum planning provides expertise in areas related to (1) clinical management, (2) counseling, (3) literature and other educational materials, (4) community resources,

Table 1. Teaching strategies in family medicine in residency and medical school

Residency (n=202)		*Medical school* (n=62)	
Lecture	87.1%	Lecture	79.0%
Clinical Care	75.7%	Readings	79.0%
Films	69.3%	Films	63.9%
AA Meetings	67.3%	Seminars	56.4%
Seminars	63.9%	Demonstrations	55.7%
Demonstrations	61.9%	AA Meetings	54.8%
Readings	59.9%	Self-Instruction	47.5%
Conferences	56.4%	Experiential	47.5%
Experiential	54.5%	Clinical Care	38.7%
Self-Instruction	43.1%	Conferences	36.0%
Research	5.0%	Research	6.5%

and (5) treatment philosophy. It also enlists community support for finding and arranging for guest speakers and clinical training sites and aid in community relationship problem-solving. Lastly, it establishes credibility of the teaching program within the treatment community.

- Team teaching involving family physicians and nonphysicians

Team teaching helps to teach concepts of team building and therapeutic effectiveness while simultaneously providing a family physician role model.

- Use of experiential teaching strategies

A variety of strategies used in combination is recommended, with ideal options including simulated patients, case presentations, demonstration interviews, and patient panels.

- Clinical application within the family practice office setting

It is desirable to expose students to alcohol and other drug abusing patients within the family practice office setting and to incorporate teaching directly into clinical work. Some strategies to help with this include (1) using the medical record by encouraging chart notation and recording the problem or diagnosis on the problem list, (2) using family genograms, and (3) using screening instruments routinely in the clinic such as MAST or the short version thereof SMAST or the CAGE instrument.

- Clinical application within the community

Clinical experience in a treatment program (or experiences in a variety of programs) is essential. The typical short-term block rotation might, in the committee's opinion, be enhanced by (1) total immersion experiences whereby a student or resident becomes a "patient" in a program or participates in an intensive, exclusive 4-week block rotation and (2) the student or resident follows a minimum of one family from diagnosis through recovery.

- Other community experiences

Attendance preferably at a minimum of two AA meetings is strongly advised. In addition, contact with or an understanding of other community support groups such as Al-Anon, Al-Ateen, or NA is suggested.

Future Plans

Many respondents to the curriculum survey had a teaching program currently in place but had no plans to expand or modify it. Presumably, they had not identified any problems or deficiencies, or at least none major enough to require changes. Where plans were indicated, they were directed toward the following:

1. Expand community-based clinical experiences
2. Obtain more curriculum time
3. Increase relevance of teaching to clinical practice
4. Continue to refine existing curriculum
5. Identify useful resources
6. Improve impaired physician teaching
7. Liaison with other departments
8. Faculty development

EVALUATION

The basic principles and methods for evaluating alcohol and other drug abuse curricula do not differ fundamentally from evaluation in other areas of medical education. One possible exception is in attitude measurement and change. Because attitudes have been emphasized as an important topic for alcohol and other drug abuse teaching, they may warrant a more detailed evaluation than other areas of a medical curriculum.

for evaluation of the student, the teacher, and the program thus flow logically from the objectives and permit an easy assessment of needed changes.

Short-term evaluation is the type most commonly used in medical education. It provides immediate feedback to student and teacher but does not measure desired long-term behavioral changes. Ideally, these should be measured through evaluation systems designed to assess changes in

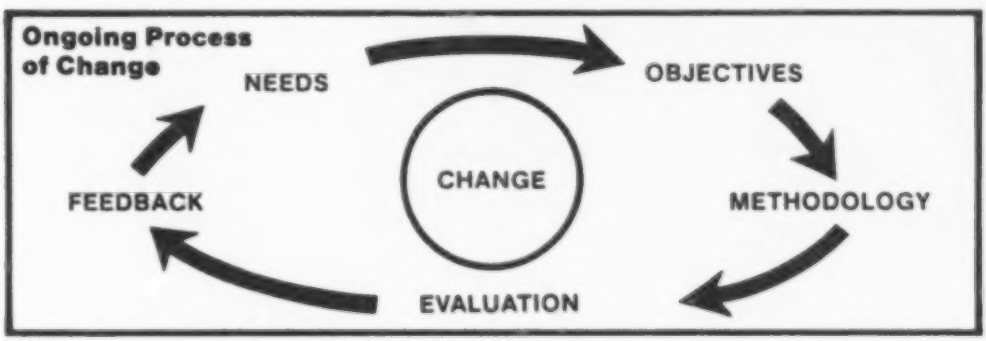


Figure 2 (taken from *Predoctoral Education in Family Medicine*, Task Force on Predoctoral Education, STFM 1981) illustrates the feedback loop in the evaluation process. At its best, evaluation is a dynamic process providing information for the learner and for the teacher. It stimulates improvement in both and promotes revision in the learning experience. Respondents to the survey indicated that evaluation is a weakness in current alcohol and other drug abuse teaching.

Evaluation should be linked to the goals and objectives. Well thought-out goals and objectives are essential because they form the basis for the evaluation system. They should therefore be *measurable*. Criteria

performance over longer periods to demonstrate permanent changes in patterns of medical practice. Such comprehensive systems are rarely used because of the difficulty and expense involved.

Evaluation can target the learner, the program or teacher, and oneself. These are briefly discussed below.

Evaluation of the learner is keyed to the objectives of the learning unit. Knowledge and skills are assessed through direct observation of patient care, pre- and post-tests, multiple-choice questions, patient management problems, oral examinations, live simulated patients, and computer simulations. Attitudes may be assessed through semantic differential and other

attitude instruments. There are also summative and formative forms of evaluating the learner. Formative evaluation is designed to provide information and feedback during a learning experience. This is done in a way that encourages the measurement of behavioral change, the provision of further feedback, and ideally an improvement in performance. Summative evaluation is terminal and therefore does not permit the measurement of improvement during an experience.

Evaluation of the program and teacher addresses questions about program planning and administration. It also attempts to evaluate appropriateness of the learning materials/resources and learning experiences. Coupled with this are questions concerning clinical application of the teaching or of the setting where teaching occurs. Included here is evaluation of the evaluation system.

Evaluation of the teacher is more than an evaluation of personality. It includes descriptive and objective measures, such as the student's ability to learn from the experiences designed by the teacher, from the opportunities provided, and from the feedback given by the teacher. Most institutions have a predesigned form that covers all clerkships but, again ideally, a teacher evaluation form should measure whether specified course goals are met through the efforts of the teacher.

Self-Evaluation may use contracts and learning plans, which are becoming popular as a method of developing an experience that more closely fits the individual needs of the learner. They are usually oriented toward achieving specific individualized learning objectives.

In summary, evaluation is a dynamic tool providing opportunities for individual review, for looking at the connection between teaching and learning, and for promoting change where necessary. For more indepth information on evaluation in family medicine, we refer you to the references below.

- McGaghie, W.C., and Frey, J.J., eds. *Handbook for the Academic Physician*. New York: Springer-Verlag, 1986.
- Corley, J.B. *Evaluating Residency Training*. Lexington, MA and Toronto: The Collamore Press, D.C. Heath and Company, 1983.
- *Predoctoral Education in Family Medicine*. Kansas City, MO: The Task Force on Predoctoral Education of the Society of Teachers of Family Medicine; 1981.

Evaluation Assessment Tool

Table 2 may be useful both as a "diagnosis of evaluation" tool and as an evaluation assessment tool.

Table 2. Evaluation assessment tool
(Drawn from Educational Goals and Objectives Chapter)

MAJOR GOALS AREAS		ATTITUDES	KNOWLEDGE	SKILLS
I.	GENERAL CONCEPTS Definitions Criteria Natural History Epidemiology Family			
II.	PREVENTION			
III.	PATHOPHYSIOLOGY			
IV.	EVALUATION OF PATIENT Diagnosis History Taking Physical Exam Lab Investigations			
V.	MANAGEMENT OF PATIENT Intervention Acute Management Referral Self-Help Groups Long-Term Management Psychotropic Meds. Ther. Relationship			
VI.	LEGAL ASPECTS			
VII.	HEALTH PROFESSIONAL IMPAIRMENT			

CURRICULUM EXAMPLES

From among the various curriculum materials submitted with the survey data by many programs, we selected a few for indepth description. They represent varied approaches to the presentation of alcohol and other drug abuse teaching in the medical school and residency curricula. A contact person, address, and telephone number are listed for each.

The Advisory Committee decided to choose curriculum units that demonstrate variations in the following characteristics:

- Required versus elective or selective
- Block (a separate unit that stands alone) versus integrated or longitudinal (the unit is meshed with another larger course or the alcohol and other drug abuse curriculum is built into the larger curriculum's components
- In-house (teaching takes place at the medical school, hospital, or residency training program and is conducted for the most part by university affiliated faculty) versus community-based teaching (the learning experience is located outside of the university/institutional setting and is taught for the most part by community-based specialists in alcohol and/or other drug abuse).

Medical School Example of Required/ Integrated/In-house Curriculum Unit in Introduction to Clinical Medicine Course (Year 1)

Curriculum Integration Strengths

A 2-hour unit integrated into a required course

Pre- and post-test evaluations of participants

Evaluation of the unit

Learning Goal and Objective Areas

General Concepts
Prevention
Diagnosis: History taking; laboratory investigations; diagnosis through family members
Intervention
Family
Attitudes

Strategies

Lecture
Handouts and slides
Self-made videotape of interview with alcoholic family

Contact Person:

Macairn Baird, M.D.
Dept. Family Medicine
University of Oklahoma
800 NE 15th St., Room 503
Oklahoma City, OK 73190
Phone: 405-271-8000

Medical School Example of Elective/ Integrated/Community Curriculum Unit in Introduction to Clinical Medicine Course (Year 1)

Curriculum Integration Strengths

Elective chemical dependency experience integrated into a larger required course

Provision of community setting experience to augment didactic learning in relation to interview techniques and difficult patient management situations within a larger course

Setting options (up to three) are available for a large range of experiences within both alcohol and other chemical dependency

Learning Goal and Objective Areas

Attitudes
Diagnosis: Early warning signs, screening instruments, history taking
Patient management
Referral
Self-help groups
Therapeutic relationship and team management

Strategies

Multiple sessions per month are available with options for a 1- or 2-day experience

Visits to community treatment center

Direct participation in patient interview and group sessions

Discussion with professional staff at the treatment center

Contact Person:

Maureen Strohm, M.D.
Department of Family Medicine
USC School of Medicine
2025 Zonal Ave.
Parkview Medical Building, B-207
Los Angeles, CA 90033
Phone: 213-224-7711

Medical School Example of Required/ Integrated/In-house Community Curriculum Unit in a Family and Community Medicine Clerkship
(Year 3)

Curriculum Integration Strengths

Combination of clerkship faculty participating in in-house teaching with visits to community sites

Comprehensive evaluation of participants and of the unit

Evaluation results suggest attitude change as greatest area of student improvement

Learning Goal and Objective Areas

Attitudes
Prevention
Diagnosis: History taking
Long-term management
Referral
Health professional impairment

Strategies

Module in clerkship in seven sites

Two seminars in which faculty present tapes and lead discussions on drug and alcohol abuse (using the film "Alcoholism and the Physician Parts I-IV")

Use of outside speakers at seminars

1-2 days in a treatment facility observing intake interviews and group sessions with the opportunity for more indepth interviewing

Opportunity for discussions with treatment center staff

Attendance at an AA meeting

Contact Person:

Jack Rodnick, M.D.
Marilyn Little, Ph.D.
Department of Family Medicine
University of California
400 Parnassus Ave. AC-9
San Francisco, CA 94143
Phone: 415-476-1482

Medical School Example of Selective/ Integrated/In-house Community Curriculum Unit
(Year 4)

Curriculum Integration Strengths

One of six 1-week mini-modules in a Basic Science of Family Medicine Fourth Year Selective

Combining in-house teaching/discussion with a community experience (attendance at an AA meeting)

Evaluation of the unit and participant (the latter drawing on case management problems from real patients in the primary care setting)

Small-scale course that allows for meeting individual needs and interests such as ongoing student support group

Learning Goal and Objective Areas

Physician impairment
Attitudes
Diagnosis
Pathophysiology
Intervention
Family
Self-help groups
Referral

Strategies

Assessment of students' prior experience on Day One to tailor learning experience

Written self-reflective assignments evaluating student and unit

Seminars combining films, outside speakers, discussion groups, case presentations, and role playing

Contact Person:

Maureen Strohm, M.D.
Dept. Family Medicine
USC School of Medicine
2025 Zonal Ave.
Parkview Medical Building, B-207
Los Angeles, CA 90033
Phone: 213-224-7711

Medical School Example of Selective/Block/ Community Curriculum Unit on Alcoholism Rehabilitation (Year 4)

Curriculum Integration Strengths

Direct interaction with *both* patients and health care professionals, including physicians

Flexible and individually tailored to students' schedules and needs

Varied clinical experiences at a community treatment center

Evaluation of unit and participant

Learning Goals and Objective Areas

Diagnosis: History taking
Acute management
Intervention
Referral
Long-term management
Therapeutic relationship
Pathophysiology
Family
Attitudes

Strategies

Two-week community experience within a 4-week clerkship

Three community settings available for experiences in both chemical dependency and alcoholism treatment

Clinical exposure in treatment centers includes rounds, staff meetings, participation/observation in/of group therapy, education classes

Attendance at AA and Al-Anon meetings

Readings

Provision of large selection of audio-visual materials in community treatment settings

Contact Person:

John Kish, Ph.D.
School of Nursing
Medical College of Ohio
CS # 1008
Toledo, OH 43699
Phone: 419-381-5129

Residency Example of Required/Integrated/ In–House Curriculum

Curriculum Integration Strengths

Needs assessment of faculty preceded development of learning goals and competencies

Goals elaborated in behavioral terms

Strategies to meet goals developed *after* goals and objectives were developed

Evaluation testing instruments developed

Each unit integrated to meet needs of different levels of training

Learning Goal and Objective Areas

Prevention
Diagnosis: History taking, interviewing, physical exam
Intervention and confrontation

Acute and long–term management including resources

Family support and treatment

Attitudes and personal risk

Strategies

Content.

Year 1: Attitudes, personal risk, diagnosis and resources

Years 2 and 3: In–depth diagnostic skills, acute and long–term treatment, family support and treatment

Process.

Year 1: Orientation session: Alcoholism Teaching Seminar (Small groups; films)

Self–administered learning modules

Years 2 and 3: Two units in Behavioral Medicine Block Rotation

Unit 1: Diagnosis, treatment, phy– sician role

Unit 2: Family support and treatment

Unit Activities:

Film series and small groups
Family conference series
Video precepting
AA and Al–Anon
DWI program site visit
Individual patient consults

Year 3: (Planned) Participation in local treatment center ranging from intake evaluation and observation activities to 1–month rotation

Contact Person:

James Finch, M.D.
Duke–Watts Family Medicine Program
407 Crutchfield St.
Durham, NC 27704–2799
Phone: 919–471–4421

Residency Example of Required/Integrated/ In–house Curriculum

Curriculum Integration Strengths

Curriculum integrated throughout all 3 years to reinforce learning

Learning clinically focused in family practice center

Evaluation includes clinical vignettes

Includes smoking cessation

Learning Goal and Objective Areas

Attitudes
Prevention
Early diagnosis
Patient management
Family
Impaired physician

Strategies

Content:

Year 1: Attitudes, early diagnosis, impaired physician

Years 2 and 3: Indepth diagnosis, treatment, referral, and family care

Process.

Year 1: Lecture, seminars, AA meetings (films, book of readings)

Year 2: Family Psychosocial Center (4 hours per week for 3 months during family medicine/psychiatry rotation)

Year 3: Lectures and 1-week participation in a local treatment center (to be finalized)

Contact Person:

Antonnette V. Graham, R.N., M.S.W.
UHHC-Family Medicine
University Hospital
Case Western Reserve University
2079 Abington Rd.
Cleveland, OH 441220
Phone: 216-844-3791

Residency Example of Required/Integrated/ In-house Community Curriculum

Curriculum Integration Strengths

Learning objectives stated in behavioral terms

Learning objectives integrated into composite behavioral program

Learning experiences traverse all 3 years of residency

Learning Goal and Objective Areas

General concepts
Attitudes
Diagnosis
Acute treatment
Long-term management
Pathophysiology
Referral
Self-help groups
Family

Strategies

Year 1: Orientation: Introduction to assessment, management of alcohol/ chemical problems

FPI inpatient: Integrated with inpatient care

Year 2: Supervised brief therapy of ambulatory patients with chemical and other psychiatric problems

Participation in program of private inpatient additions facility

Readings (Whitfield et al.)

Year 3: FPI inpatient

Participation in (cofacilitation of) alcoholism therapy groups

Elective experiences (e.g., extended group participation, research project, etc.)

Longitudinal: Patient care in family health center and episodic care service

Contact Person:

C. Earl Hill, M.D.
Family Practice Residency Program
22 S. Greene St.
Baltimore, MD 21201
Phone: 301-528-5012

Residency Example of Elective or Required/Block/Community Rotation of Alcohol and Other Drug Abuse

Curriculum Integration Strengths

Intensive block experience allowing examination of personal attitudes/risk while developing clinical skills

Broad coverage of objectives

Strong family physician role model

Learning through direct participation and hands-on experience

Pre- and post-test evaluation of participants

Learning Goal and Objective Areas

Attitudes

Prevention
General concepts
Diagnosis
Acute management
Family
Intervention
Long-term management
Psychotropic medications
Therapeutic relationship
Legal issues
Self-help groups
Health professional impairment

Strategies

A 1-week experience at a community treatment center

Attend all routine conferences, patient education classes, and staff meetings

Talk with family members and patients (separately)

Participate in aftercare sessions with patient, family, and physician

Attend conference on role of employee assistance program

Visit local county treatment program and other community resources

Attend AA and Al-Anon meetings in community

Contact Persons:

Al Mooney, M.D.
Susan Pajari, M.S.T.
Willingway Hospital
311 Jones Mill Road
Statesboro, GA 30458
Phone: 912-764-6236

Example of Self-Instructional Program: Elective/Integrated/In-house/Community Curriculum Unit

Curriculum Integration Strengths

Program serves as an adjunct to clinical experience in the primary care setting

Combination of community site visits and applied clinical skills with primary care patients

Provides general overview of diagnosis, intervention, and management of alcoholic patient

Can be adapted for use at any educational level including medical school, residency, CME, and for recertification purposes

Learning Goal and Objective Areas

Diagnosis: History taking; physical examination, laboratory investigations
Intervention

Acute management: Withdrawal and overdose

Pathophysiology
Attitudes
Prevention
Long-term management

Strategies

Student has one mentor or preceptor overseeing study

Provision of study guide (with an annotated bibliography) to be used in discussions with mentor

Identify and work up patient in primary care setting

Visit to local alcohol and/or drug abuse treatment facility

Attend AA and Al-Anon meeting

Written paper on alcoholic patient encouraged as topic for written paper requirement

Contact Person:

Eugene Schoener, Ph.D.
Director, Addiction Research Institute
540 E. Canfield
Detroit, MI 84201
Phone: 313-577-1388

LEARNING MATERIALS

Selection Criteria for Inclusion of Readings and Audiovisual Materials in the Resource Manual

The following sections contain annotated references to readings and audiovisual materials. It was the committee's collective opinion that publishing some descriptive information on materials actually reported to be useful would be more informative to educators than a literature search or a committee-generated list. Thus, from the curriculum materials received, all readings that were to be "required" and all films reported to be used regularly were included in this section. In addition, the committee felt that the inclusion of readings that its members had found useful would augment the survey-based list. As it turned out, all but a very few of the "committee recommended" readings were indeed being used.

The bibliography is broken down by major content according to the goals discussed under Educational Goals and Objectives. Readings are listed in alphabetical order according to the authors' last names under each goal heading. For all references, information is provided on source and educational level—Medical School (MS) or Residency (R) or both (R/MS)—at which they are reportedly being used. The readings that the committee determined were "recommended by virtue of its membership's experience" (through a totally independent process) are indicated by an "*".

The list of audiovisual materials also provides as much descriptive information as possible and the level of education where each is being used. They are in descending order by the number of programs reported using them. They are not broken down by topic under goal headings, but instead are followed by a general indication as to which goal(s) they address.

BIBLIOGRAPHY

Attitudes

Chappel, J.N. Physician attitudes and the treatment of drug dependent patients. *Journal of Psychedelic Drugs* 10(1): 27–33, Jan.–Mar., 1978. R

Kinney, J., Bergen, B.J., and Price, T.R.P. A perspective on medical students' perceptions of alcoholics and alcoholism. *Journal of Studies on Alcohol* 43(5): 488–496, 1982. R

Lisansky, E.T. Why physicians avoid early diagnosis of alcoholism. *New York State Medical Journal* 75(10):1788–1792, 1975. MS

Strachan, J.G. A complexity of attitudes. In: *Alcoholism: Treatable Illness.* Vancouver: Mitchell Publications, 1968. pp. 31–48. R

General Concepts

Abel, E.L. Prenatal effects of alcohol on growth: A brief review. *Federation Proceedings* 44(7):2318–2322, 1985. MS

American College of Physicians Health and Public Policy Committee. Chemical dependence (position paper). *Annals of Internal Medicine* 102:405–408, 1985. R

Anonymous. Losing control: A personal perspective on alcoholism. *Osteopathoc Annals* 13:31–33, 1985. R

Anonymous. Adverse effects of cocaine abuse. *The Medical Letter* 26:662, 1984. R

Blume, S.B. The alcoholism in our patients. *Harvard Medical Alumni Bulletin* 54(6):7–9, 1980. R

Buffum, J., and Yeary, J. How alcohol, tobacco and other drugs tamper with your real response. *Sexology Today* 10–17, 1981. R

Clarren, S.K. Recognition of fetal alcohol syndrome. *Journal of the American Medical Association* 245(23):2436–2439, 1981. R/MS

Dougherty, R. "Is cocaine use and alcoholism a problem?" Paper presented at the New York State Division of Alcohol and Alcohol Abuse Conference, White Plains, NY, 1985. R/MS

Dougherty, R. Pseudo–speed. *New York State Journal of Medicine* 82(1):74–75 1982. R

Dougherty, R. Status of cocaine abuse 1984. *Journal of Substance Abuse Treatment* 1:157–161, 1984. R/MS

Inboden, W.C. Unique aspects of adolescent chemical dependency. *Osteopathic Annals* 13:12–16, 1985. R

Jellinek, E.M. Phases of alcohol addiction. *Quarterly Journal of Studies on Alcohol* 13(4):673–684, 1952. R/MS

Klatsky, A.L. Alcohol and mortality: A ten year Kaiser–Permanente experience. *Annals of Internal Medicine* 95:139–145, 1981. R

MacDonald, D.I. Drugs, drinking and adolescence. Chicago: *Year Book Medical Publishers*, 1984. MS

Mooney, A.J. Pharmacologic basis of symptoms. *Consultant* May 1983. R

Mulry, J.T. Chemical dependency: A unified illness. *American Family Physician* 29(3):285–290, 1984. R

Nicholi, A.M. The nontherapeutic use of psychoactive drugs. *New England Journal of Medicine* 308(16):925–931, 1983. R

Ohlms, D.A. *The Disease Concept of Alcoholism.* Belleville, IL: Gary Whiteaker Co., 1983. R

Ohlms, D.A. *Pot.* Belleville, IL: Gary Whiteaker Co., 1983. R

Schuckit, M.A. A clinical review of alcohol, alcoholism and the elderly patient. *Journal of Clinical Psychology* 43(10): 396, 1982. R/MS

Schwartz, R.H. Frequent marijuana use in adolescence. *American Family Physician* 31(1):201–205, 1985. R

Talbott, D. Alcoholism the disease—A medical fact. *Journal of the Medical*

Association of Georgia 64:331–333, 1975. R

Vaillant, G.E. Alcoholism and drug dependence. In: Nicholi, A.M., ed. *Harvard Guide to Modern Psychiatry*. Cambridge, MA: Belknap Press, 1978. pp. 567–577. R

Vaillant, G.E., and Milofsky, E.S. Natural history of male alcoholism: IV. Paths to recovery. *Archives of General Psychiatry* 39:127–133, 1982. R/MS

West, L.J.; Maxwell, D.S.; Noble, E.P.; and Solomon, D.H. Alcoholism (UCLA conference). *Annals of Internal Medicine* 100:405–416, 1984. R

Family

Ablon, J. Al-Anon family groups. *American Journal of Psychotherapy* 28:30, 1974. R

Anderson, S.C., and Henderson, D.C. Family therapy in the treatment of alcoholism. *Social Work in Health Care* 8(4):79–94, 1983. R

Baird, M. Chemical dependency: A protocol for involving the family. *Family Systems Medicine* 3(2):216–220, 1985. R

Black, C. *It Will Never Happen to Me*. Denver: MAC Printing and Publication Division, 1982. R

Jackson, J. The adjustment of the family to the crisis of alcoholism. *Quarterly Journal of Studies on Alcohol* 15:562–586, 1954. R/MS

Jacob, T.; Dunn, N.J.; and Leonard, K. Patterns of alcohol abuse and family stability. *Alcoholism: Clinical and Experimental Research* 7(4):382–385, 1983. R

Kaufman, E. Family system variables in alcoholism. *Alcoholism: Clinical and Experimental Research* 8(1):4–8, 1984. R

Lanier, D.C. Familial alcoholism. *Journal of Family Practice* 18(3):417–422, 1984. R

Leckman, U.B. Alcoholism in families of family practice outpatients. *Journal of Family Practice* 19(2):205–207, 1984. R/MS

Liepman, M.R. Helping alcoholics through manipulation of social resources. *Seminars in Family Medicine* 1(4):271–281, 1980. R

Smith, D.E., and Yeary, J. Dealing with family problems caused by substance abuse. *Medical Aspects of Human Sexuality,* in press. R

Wegscheider, S. *Another Chance: Hope and Health for the Alcoholic Family*. Palo Alto: Science and Behavior Books, 1981. R/MS

Wolin, S.J.; Bennett, L.A.; and Noonan, D.L. Family rituals and the recurrence of alcoholism over generations. *American Journal of Psychiatry* 136(4B):589–593, 1979. R

Prevention

Borg, V. Bromocriptine in the prevention of alcohol abuse. *Acta Psychiatry Scandinavia* 68:100–110, 1983. R

Jurich, A.P., and Polson, C.J. Reasons for drug use: Comparison of drug users and abusers. *Psychological Reports* 55(2): 371–378, 1984. R

Milam, J.R., and Ketcham, K. What makes an alcoholic: Predisposing factors. *Under the Influence—Guide to Myths and Realities of Alcoholism.* Seattle: Madrona Publications, 1981. pp. 31–46. R

Pathophysiology

Symposium on ethyl alcohol and disease. *Medical Clinics of North America* 68(1):1–255, 1984. R

Clark, L.T. Alcohol use and hypertension: Clinical considerations and hypertension. *Postgraduate Medicine* 75(8):273–276, 1984. R

Eckardt, M.J. Health hazards associated with alcohol consumption. *Journal of the American Medical Association* 246(6): 648–666, 1981. R/MS

Fallon, H.J., and Lesesne, H.R. Medical complications of excessive drinking. In: Ewing, J.A., and Rouse, B.A., eds. *Drinking Alcohol in American Society*. Chicago: Nelson-Hall, 1978. MS

Food and Drug Administration. *FDA Drug Bulletin: Alcohol–Drug Interactions*. DHEW Publication. Rockville, MD: the Administration, 1979. R

Goodman, L.S., and Gilman, A., eds. *The Pharmacologic Basis of Therapeutics*. New York: MacMillan, 1975. MS

Isselbacher, K.J. Metabolic and hepatic effects of alcohol. *New England Journal of Medicine* 296(11):612–616, 1977. R

Lieber, C.S. Pathogenesis and early diagnosis of alcoholic liver injury. *New*

England Journal of Medicine 298(16): 888–893, 1978. R

Maddrey, W.C., and Imboden, J.B. Alcoholism and associated medical problems. In: Harvey, M.; Johns, R.J.; Owens, A.H.; and Ross, R.S., eds. *Principles and Practice of Medicine.* 20th ed. New York: Appleton–Century–Crofts, 1980. pp. 1449–1455. MS

Mendelson, J.H., and Mello, N.K. Biologic concomitants of alcoholism. *New England Journal of Medicine* 301:912, 1979. R

Packard, R.C. The neurologic complications of alcoholism. *American Family Physician* 14(3):111–115, 1976. R

Seixas, F.A. Alcohol and drug interactions. *Annals of Internal Medicine* 83:86–92, 1975. R

Troncale, J.A. Endocrine effects of alcoholism. *Journal of Family Practice* 19(1):17–32, 1984. R

Evaluation of the Patient

Alcenas Hospital. *How to Identify the 300 Alcoholics in Your Practice.* Kirkland, WA: Alcenas Hospital, 1980. R

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders–DSM III.* Washington, D.C.: the Association, 1980. R

Bates, R.C. The hidden alcoholic: A history that reveals the early clues. *Diagnosis* 1(2):22–27, 1979. R

Beresford, T.; Low, D.; Hall, R.C.W.; Adduci, R.; and Goggans, F. A computerized biochemical profile for detection of alcoholism. *Psychosomatics* 23(7):713–720, 1982. R

Brady, J.P.; Foulks, E.T.; Childress, A.R.; and Pertschuk, M. The MAST as a survey instrument. *Journal of Operational Psychiatry* 13(1):27–31, 1982. R

Callahan, E.J., and Pecsok, E.H. Behavioral assessment of heroin addiction. In: Marlatt, A., and Donovan, D., eds. *Assessment of Addictive Behaviors.* New York: Guilford Press, in press. R

Clark, T.H.; Liepman, M.; Whitfield, C.; and Williams, K.H. A protocol for identifying alcoholism (practice aids). *Patient Care* 13(11):154–162, 1979. R

Coller, J.J., and Hirschfield, J. Doctor, you are missing the diagnosis of 10% of your patients—Why? A checklist. *Maryland State Medical Journal* 30(8):26–27, 1981. MS

Cross, G., and Mooney, A.J. Office diagnosis of alcoholism. *Georgia Academy of Family Practice Journal* 6(4), 1985. R

Ewing, J.A. Detecting alcoholism: The CAGE questionnaire. *Journal of the American Medical Association* 252(14): 1905–1907, 1984. R/MS

Feighner, J.P. Diagnostic criteria for use in psychiatric research. *Archives of General Psychiatry* 26:57–63, 1972. R

Gale, J., and Marsden, P. The role of the routine clinical history. *Journal of Medical Education* 18:96–100, 1984. R

Holt, S., and Skinner, H.A. Early identification of alcohol abuse: II. Clinical and laboratory indicators. *Canadian Medical Association Journal* 124:1279–1293 1981. R

Hood, B. Tracing and handling of high alcohol consumption with the aid of laboratory means (editorial). *European Journal of Clinical Investigation* 11: 147–148, 1981. R

Hotch, D.F.; Sherin, K.M.; Harding, P.N.; and Zitter, R.E. Use of the self-administered Michigan alcoholism screening test in a family practice center. *Journal of Family Practice* 17(6):1021–1026, 1983. R

Mooney, A.J. Alcohol use. In: Taylor, R., ed. *Health Promotion: Principles and Clinical Applications.* New York: Appleton–Century–Crofts, 1982. pp. 233–258. R/MS

Morse, R.M., and Hurt, R.D. Screening for alcoholism. *Journal of the American Medical Association* 242(24):2688–2690, 1979. R

National Council on Alcoholism. Criteria for the diagnosis of alcoholism. *American Journal of Psychiatry* 129:127–135, 1972. R/MS

Selzer, M.L. The Michigan alcoholism screening test: Quest for a new diagnostic instrument. *American Journal of Psychiatry* 127:12, 1971. R/MS

Silberfarb, P.M. Recognizing alcoholism by early signs. *Postgraduate Medicine* 59(4): 79–81, 1976. R

Skinner, H.A., and Holt, S. Early identification of alcohol abuse: I. Critical issues

and psychosocial indicators for a composite index. *Canadian Medical Association Journal* 124:1141–1142, 1981. R

Skinner, H.A.; Holt, S.; Schuller, R.; and Roy, J. Identification of alcohol abuse using laboratory tests and a history of trauma. *Annals of Internal Medicine* 101:847–851, 1984. R

Sokol, R.J., and Miller, S.I. Identifying the alcohol-abusing obstetrical/gynecologic patient: A practical approach. *Alcohol Health and Research World* 4(4):36–40, 1980. R

Unknown. Recognizing the middle-class pill pusher. *Diagnosis* 2(3):40–52, 1980. R

Valaske, M.J. Laboratory clues suggesting alcoholism. *Maryland State Medical Journal* 29(10):59–61, 1980. R

Weinberg, J.R. Interview techniques for diagnosing alcoholism. *American Family Physician* 9(3):107–115, 1974. R/MS

Management of the Patient

Ackerman, R.J. *Children of Alcoholics–A Guidebook for Educators, Therapists and Parents.* Holmes Beach, FL: Learning Publications, Inc., 1978. R

Alcoholics Anonymous. *Alcoholics Anonymous.* New York: Alcoholics Anonymous World Services, 1976. R

Anonymous. Double withdrawal for the double addict. *Emergency Medicine* 12(5):77, 1980. R

Bean, M. Alcoholics Anonymous. *Psychiatric Annals* 5:2, 1975. R

Brown, C.G. The alcohol withdrawal syndrome. *Annals of Emergency Medicine* 11(5):276–280, 1982. R

Callahan, E.J. Alternative strategies in the treatment of addiction: A review. In: Miller, W.R., ed. *The Addictive Behaviors.* Chap. 3. Oxford: Pergamon Press, 1980. R

Cass, A.R.; Frazier, S.H.; and Schanbacher, M. *Alcoholism and Alcohol Abuse Reference Guide 14.* New York: American Board of Family Practice, 1983. R

Clark, W.D. Alcoholism: Blocks to diagnosis and treatment. *American Journal of Medicine* 71:275–286, 1981. R/MS

Collins, G.B. Treatment of alcoholism–Role of the primary care physician. *Postgraduate Medicine* 69(1):6–10, 1981. MS

Craigie, F.C. Therapeutic homework: The use of behavioral assignments in office counseling. *Journal of Family Practice* 20(1):65–71, 1985. R

Cummings, S.R. Kicking the habit: Benefits and methods of quitting cigarette smoking. *Western Journal of Medicine* 137(5):443–447, 1982. R

Digregorio, G.J., and Bukovinsky, M.A. Clonidine for narcotic withdrawal. *American Family Physician* 24(3):203–204, 1981. R

Doherty, W., and Baird, M. Treating chemical dependency in a family context. *Family Therapy and Family Medicine: Toward the Primary Care of Families.* New York: Guilford Press, 1983. R/MS

Dougherty, R. Transcutaneous electrical nerve stimulation in the treatment of chronic pain. *Hospital Formulary* 16(2):167–170, 1981. R/MS

Dougherty, R. Office management of chronic pain. *Postgraduate Medicine* 76(2):215–217, 1984. R/MS

Farris-Kurtz, L. Time in residential care and participation in AA as predictors of continued sobriety. *Psychological Reports* 48:633–634, 1981. R

Finney, J.W.; Moos, R.F.; and Chan, D.A. Length of stay and program component effects in the treatment of alcoholism: A comparison of two techniques for process analysis. *Journal of Consulting and Clinical Psychology* 49(1):120–131, 1981. R

Fisher, J.V. The family physician's role in managing alcohol and drug abuse: A response to Stephen's decalogue. *Continuing Education for the Family Physician* Mar:129–132, 1984. R

Glass, G. Recognizing and managing the outpatient alcoholic. *American Family Physician* 15(3):176–182, 1977. R

Graham, A.V.; Sedlacek, D.; Reeb, K.G.; and Thompson, J.S. Early diagnosis and treatment of alcoholism. *Journal of Family Practice* 19(3):297–313, 1984. R

Groves, J.E. Taking care of the hateful patient. *New England Journal of Medicine* 298:883, 1978. R

Grutchfield, L. AA as a learning tool. *Employee Assistance Program Digest* Mar.–Apr:37–40, 1986. MS

Harper, R.G.; Solish, G.I.; Purow, H.M.; Sang, E.; and Panepinto, W.C. The effect of a methadone treatment program upon pregnant heroin addicts and their newborn infants. *Pediatrics* 54(3):300–304, 1974. R

Hill, P.S. Alcoholism: Images, impairments, interventions. *Postgraduate Medicine* 74(5):87–99, 1983. R

Khantzian, E.J. Acute toxic and withdrawal reactions associated with drug use and abuse. *Annals of Internal Medicine* 90:361–372, 1979. R

Kleber, H.D. Clonidine in outpatient detoxification from methadone maintenance. *Archives of General Psychiatry* 42:391–393, 1985. R

Kleber, H.D. The clinical use of naltrexone: Potential candidates. *Substance Abuse Bulletin* 1(2):1–4, 1985. R

Miller, G.W. Principles of alcohol detoxification. *American Family Physician* 30(4):145–148, 1984. R/MS

Minter, R., and Murray, G.B. Diazepam withdrawal: A current problem in recognition. *Journal of Family Practice* 7(6):1233–1235, 1978. R

National Institute on Drug Abuse. *Detoxification treatment manual.* National Institute on Drug Abuse Treatment Monograph Series No. 6. Rockville, MD: the Institute. R

National Institute on Drug Abuse. *Naltrexone: Its clinical utility.* National Institute on Drug Abuse Treatment Research Report. Rockville, MD: the Institute. R

Ohlms, D.A. *The Prescription Trap.* Belleville, IL: Gary Whiteaker Co., 1983. R

Reilly, R.L. Five most common errors made by primary care physicians treating alcoholics. *Osteopathic Annals* 12: 115–122, 1984. MS

Schachter, S. Recidivism and self-cure of smoking and obesity. *American Psychologist* 37(4):436–444, 1982. R

Schuckit, M.A. Disulfiram and the treatment of alcoholic men. *Advances in Alcoholism* 2(4), 1981. R

Sellers, E.M.; Naranjo, C.A.; and Peachey, J.E. Drug therapy—Drugs to decrease alcohol consumption. *New England Journal of Medicine* 305(21):1255–1262, 1981. R

Sellers, E.M., and Kalant, H. Alcohol intoxication and withdrawal. *New England Journal of Medicine* 294(14):757–762, 1976. R/MS

Siegal, H.A., and Rudisill, J. The weekend intervention program: Identifying and confronting problem drinkers. *New Family Practice Teaching Activities* 6(3), 1984. R

Stephens, G.G. A decalogue for the management of alcohol and drug abuse. *Continuing Education for the Family Physician,* 1984. p. 125. R/MS

Waldo, M., and Gardiner, T. Vocational adjustment patterns of alcohol and drug misusers following treatment. *Journal of Studies on Alcohol* 45(6):547–549, 1984. R

Weinberg, J.R. *AA: An interpretation for the professional.* New York: Alcoholics Anonymous General Services Organization. R/MS

Whitfield, C.L. Outpatient management of the alcoholic patient. *Psychiatric Annals* 12(4):447–459, 1982. MS

Zimberg, S. *The Clinical Management of Alcoholism.* New York: Brunner/Mazel, 1982. MS

Legal Issues

Chapman, S. Can you spot the games patients play to get the pills? *Legal Aspects of Medical Practice* 7(7):32–35, 1979. R

Health Professional Impairment

Bissel, L., and Jones, R.W. The alcoholic physician: A survey. *American Journal of Psychiatry* 133:1142–1146, 1976. R

Herrington, R.E.; Benzer, D.G.; Jacobson, G.R.; and Hawkins, M.K. Treating substance use disorders among physicians. *Journal of the American Medical Association* 247(16):2253–2257, 1982. R

Hyde, G.L., and Dougherty, R. Alcoholism and the physician . . . Thoughts on my brothers keeper. *The Phi Gamma Delta* Summer 1984. R

Mooney, J. No alcoholic doctor's case is hopeless. Take mine. *Medical Economics* 55(18):86–106, 1978. R

Vaillant, G.E.; Sobowale, N.C.; and McArthur, C. Some psychological vul-

nerabilities of physicians. *New England Journal of Medicine* 287(8):372–375, 1972. R/MS

All or Most Topics

American Board of Family Practice. Alcoholism and Alcohol Abuse. Reference Guide #14. New York: the Board, 1983. R

Anderson, R.C., et al. Alcoholism and substance abuse. In: Taylor, R.B., ed. *Family Medicine: Principles and Practice.* 1st ed. New York: Springer–Verlag. MS

Coggan, P.G. Alcoholism. In: Eisenberg, M., and Cummins, R., eds. *Blue Book of Medical Diagnosis.* Philadelphia: Saunders, 1986. R

Gitlow, S.E., and Peyser, H.S., eds. *Alcoholism—A Practical Treatment Guide.* New York: Grune and Stratton, 1980. R/MS

Johnson, V.E. *I'll Quit Tomorrow.* San Francisco: Harper and Row, 1980. 182 pp. R/MS

Mendelson, J.H., and Mello, N.K. *Diagnosis and Treatment of Alcoholism.* 2d ed. New York: McGraw–Hill, 1985. R

Mooney, A.J. Alcohol use and dependence. In: Taylor, R., ed. *Family Medicine: Principles and Practice.* 2d ed. New York, Heidelberg, and Berlin: Springer–Verlag, 1983. R

Whitfield, C.L.; Davis, J.E.; and Barker, R.L. *A Synopsis of Alcoholism and Other Drug Problems.* Baltimore: The Resource Group, 1981. R

Wilford, B.B. *Drug Abuse: A Guide for the Primary Care Physician.* Chicago: American Medical Association, 1981. R

AUDIOVISUAL MATERIALS REPORTED TO BE USEFUL BY PROGRAMS SURVEYED

(Listed in order by number of programs reported using them)

Alcoholism and the Physician. Parts I–IV. Operation Cork, Gerald T. Rogers Production. Suite #6, 5225 Old Orchard Road, Skokie, IL 60077; 312–967–8080.
Each part 20 minutes. R/MS
Attitudes, general concepts, evaluation of patient, patient management.

Soft Is the Heart of a Child. Operation Cork, Gerald T. Rogers Production. Suite #6, 5225 Old Orchard Road, Skokie, IL 60077; 312–967–8080.
28 minutes. R/MS
General concepts, family.

The Intervention. The Johnson Institute. 10700 Olson Memorial Highway, Minneapolis, MN 55441–6199; 612–341–0435.
31 minutes. R/MS
General concepts, patient management, family.

Our Brother's Keeper. Operation Cork, Gerald T. Rogers Production. Suite #6, 5225 Old Orchard Road, Skokie, IL 60077; 312–967–8080.
57 minutes or 35 minutes. R/MS
Health professional impairment.

Chalk Talk on Counseling. FMS Productions, Inc. 1777 North Vine Street, Los Angeles, CA 90028; 213–461–4567.
22 minutes. R/MS
Patient management.

If You Loved Me. Operation Cork, Gerald T. Rogers Production. Suite #6, 5225 Old Orchard Road, Skokie, IL 60077; 312–967–8080.
54 minutes. R
General concepts, family.

The Family Trap. Health Communications, Inc. 2119–A Hollywood Boulevard, Hollywood, CA 33020; 305–920–9435.
30 minutes. R
General concepts, evaluation of patient, patient management, family.

Disease Concept of Alcoholism, II. Gary Whiteaker Co. 5204 West Main Street, Belleville, IL 62223; 618–277–0560; 800–851–5406.
35 minutes. R

Attitudes, general concepts, pathophysiology.

Doctor, You've Been Lied To. Ayerst Laboratories. 685 Third Avenue, New York, NY 10017.
27 minutes. R/MS
Patient management.

The Enablers. The Johnson Institute. 10700 Olson Memorial Highway, Minneapolis, MN 55441–6199; 612–341–0435.
23 minutes. R
General concepts, evaluation of patient, family.

I'll Quit Tomorrow. The Johnson Institute. 10700 Olson Memorial Highway, Minneapolis, MN 55441–6199; 612–341–0435.
90 minutes. R/MS
General concepts, evaluation of patient, patient management, family.

Medical Aspects of Alcoholism. Parts 1 and 2. Southerby Productions, Inc. 5000 East Anaheim Street, Long Beach, CA 90804; 213–434–3446.
54 minutes. R
General concepts, pathophysiology.

Calling the Shots. Cambridge Documentary Films. P.O. Box 385, Cambridge, MA 02139; 617–354–3677.
30 minutes. R
General concepts, prevention.

The Twelve Steps of AA. Father Martin Associates. 8 Howard Street, Aberdeen, MD 21001; 301–272–1975.
Patient management. R

Alcoholism: Early Diagnosis and Management. American Medical Association, Division of Marketing Services. 535 North Dearborn Street, Chicago, IL 60610; 312–751–6000.
3/4" and 1/2" video. R
Evaluation of patient, patient management, pathophysiology.

Drug Abuse in Adolescents (NCME #457). Network for Continuing Medical Education. 15 Columbus Circle, New York, NY 10023; 212–541–8088.
General concepts. R

The New Life of Sandra Blain. Part 2. Southerby Productions, Inc. 5000 East Anaheim Street, Long Beach, CA 90804; 212–434–3446.
25 minutes. R
Patient management.

The Prescription Trap. Gary Whiteaker Co. 5204 West Main Street, Belleville, IL 62223; 618–277–0560; 800–851–5406.
Patient management. R

The Secret Love of Sandra Blain. Part 1. Southerby Productions, Inc. 5000 East Anaheim Street, Long Beach, CA 90804; 212–434–3446.
25 minutes. R
General concepts, patient management.

Substance Use Disorders – Diagnosis and Management (NCME #414). Network for Continuing Medical Education. 15 Columbus Circle, New York, NY 10023; 212–541–8088.
Evaluation of patient, patient management. R

Women and Alcohol. FMS Productions. 1777 North Vine Street, Los Angeles, CA 90028; 213–461–4567.
28 minutes. R
General concepts, patient management, family.

Alcoholism: Disease or Bad Habit (NCME #429). Network for Continuing Medical Education. 15 Columbus Circle, New York, NY 10023; 212–541–8088.
Attitudes, general concepts. R

Alcohol Use and Its Medical Consequences Slide Series. 7 parts. Milner–Fenwick, Inc. 2125 Greenspring Drive, Timonium, MD 21093; 800–638–8652.
25–64 slides. MS
Pathophysiology.

Disease Concept of Alcoholism. Father Martin Associates. 8 Howard Street, Aberdeen, MD 21001; 301–272–1975.
General concepts. R

Guidelines. Father Martin Associates. 8 Howard Street, Aberdeen, MD 21001; 301–272–1975.
45 minutes. MS
Attitudes.

Alcoholism (NOVA Television Series Program). Public Broadcasting System. 800–344–3337.
60 minutes. R/MS
Attitudes, general concepts, patient management, prevention, pathophysiology.

Pot. Gary Whiteaker Co. 5204 West Main Street, Belleville, IL 62223; 618–277–0560; 800–851–5406.
General concepts. R

Stress and the Resident. American Academy of Family Physicians. 1740 West 92nd Street, Kansas City, MO 64114; 816–333–9700.
Health professional impairment. R

Alcoholics Anonymous – An Inside View. AA World Services, Inc., General Services Office. Box 459, Grand Central Station, New York, NY 10017; 212–686–1100.

27 minutes. R

Patient management.

The Troubled Employee. Dartnell. 4660 Ravenswood Avenue, Chicago, IL 60640–9981; 312–561–4000.

25 minutes. R

General concepts, evaluation of patient.

Sex, Booze and Blues. FMS Productions. 1777 North Vine Street, Los Angeles, CA 90028; 213–461–4567.

15 minutes. R

General concepts, patient management, pathophysiology, family.

Cocaine: Beyond the Looking Glass. Hazelden Educational Services. Box 176, Center City, MN 55012; 800–328–9000; 612–257–2905.

30 minutes. R

General concepts.

EDUCATIONAL MATERIAL RESOURCES

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